NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
APPLICATION FOR PROVIDER PARTICIPATION

Community Alternatives Program (CAP)

Provider Services 2506 Mail Service Center Raleigh, NC 27699- 2501 (9l9) 857-4017

DMA Use Only

SB 163 DSS_____
SB 163 DFS_____
SB 163 DMH_____
Approved_____
Denied_____
Date_____
Initial_____

An agency desiring to provide Community Alternatives Program services to N.C. Medicaid recipients must submit the original of this application to the Provider Services unit of the Division of Medical Assistance (DMA) at the above address. The application should be completed for initial enrollment as a CAP provider, for reapplication or re-enrollment and for amending a provider agreement to add CAP services/sites or to delete services/sites the agency will no longer provide. In addition to the application, provider agencies must sign a provider participation agreement. DMA will forward the provider participation agreement to the requesting provider along with details on provider qualifications for rendering CAP services. After approval of the agreement, DMA will send written notice of the assigned provider number and the CAP services approved.

A. IDENTIFICATION OF PROVIDER AGENCY

l. Name _____ Phone Number (_____)_____

E-Mail address _____ Fax Number (_____)_____

2. Location Address _____
(Street) (City) (State) (Zip)

3. Mailing Address _____
(Street) (City) (State) (Zip)

4. Type of application:

( ) Initial Enrollment
( ) Reapplication/Re-enrollment

Amendment to:

( ) Add New Service
( ) Add New Site
( ) Delete Service/Site

5. The agency (check one) ( ) is ( ) is not a current CAP provider.

Current CAP provider number(s): _____

6. List the name(s) and SSN# for individuals who own at least 5% interest in the business.

Name	Social Security Number	Percentage

Continue on back with additional names if necessary

7. _____
Name of Corporation IRS Number

(Revised 3/03)

COMMUNITY ALTERNATIVES PROGRAM SERVICES

For initial enrollment or reapplication/re-enrollment, use "X" to indicate services the provider agency will provide under each CAP Program; use "A" to add new service(s); use "D" to delete services.

1. CAP/DA (Disabled Adult) Services

( ) Adult Day Health Care
( ) Case Management
( ) Home Mobility Aids
( ) In-Home Aide Level II
( ) In-Home Aide Level III Personal Care
( ) Medicaid Medical Supplies
( ) Personal Emergency Response System (PERS)
( ) Preparation and Delivery of Meals
( ) Respite Care – In-Home
( ) Respite Care – Institutional
( ) Waiver Supplies

2. CAP/C (Disabled Children/Katie Beckett) Services

( ) Case Management
( ) CAP/C Personal Care Services
( ) Home Mobility Aids
( ) Hourly Nursing
( ) Medicaid Medical Supplies
( ) Respite Care – In-Home
( ) Respite Care – Institutional
( ) Waiver Supplies

3. CAP-MR/DD (Mentally Retarded/Developmentally Disabled) Services

( ) Adult Day Health Care
( ) Augmentative Communication Devices
( ) Case Management
( ) Crisis Stabilization
( ) Day Habilitation
( ) Developmental Day Services
( ) Environmental Accessibility Adaptations
( ) Family Training
( ) In-Home Aide Level I
( ) Interpreter
( ) Live-In Caregiver
( ) Personal Care
( ) Personal Emergency Response System (PERS)
( ) Respite Care – Institutional
( ) Respite Care – Noninstitutional Community-Based
( ) Respite Care – Noninstitutional Nursing-Based
( ) Supported Employment
( ) Supported Living
( ) Therapeutic Case Consultation
( ) Transportation
( ) Vehicle Adaptations
( ) Waiver Supplies and Equipment

4. CAP/AIDS Services

( ) Adult Day Health Care
( ) Case Management
( ) Home Mobility Aids
( ) In-Home Aide Level II
( ) In-Home Aide Level III/Personal Care
( ) Preparation and Delivery of Meals
( ) Respite Care - Institutional
( ) Respite Care – In-Home (Aide Level II)
( ) Respite Care – In-Home (Nursing)
( ) Waiver Supplies
( ) Personal Emergency Response System (PERS)

B. PROVIDER AGENCY AKNOWLEDGEMENT

I understand that the provider agency is responsible for submitting to DMA verification and documentation of its qualifications to render the CAP services indicated on this application.

C. Beginning Date Medicaid Services will be provided _____

_____
Signature of Authorized Agent for Provider Agency Date

_____
Typed or Printed Name and Title of Authorized Agent